BEST AVAILABLE IMAGES

Defective images within this document are accurate representations of the original documents submitted by the applicant.

Defects in the images may include (but are not limited to):

- BLACK BORDERS
- TEXT CUT OFF AT TOP, BOTTOM OR SIDES
- FADED TEXT
- ILLEGIBLE TEXT
- SKEWED/SLANTED IMAGES
- COLORED PHOTOS
- BLACK OR VERY BLACK AND WHITE DARK PHOTOS
- GRAY SCALE DOCUMENTS

IMAGES ARE BEST AVAILABLE COPY.

As rescanning documents *will not* correct images, please do not report the images to the Image Problem Mailbox.

Acta psychiat. scand. (1978) *58*, 80–87

Bethlem Royal and Mandsley Hospitals, London, England

Phobic partner-specific impotence in women

F. KRÄUPL TAYLOR

Functional coital impotence is not exclusive to men. It also occurs in two groups of women: those suffering from vaginismus and those with depressive episodes that give rise to a partner-specific sexual phobia. The latter syndrome is by no means uncommon, yet it has not so far attracted the attention it deserves. This neglect may be largely due to the emotional complications which ensue from it and camouflage its depressive-phobic background. It can be amenable to psychotherapeutic measures combined with antidepressant medication.

Key words: Female impotence – partner-specific sexual phobia – depressive disease – drug-assisted psychotherapy.

"If anatomical anomalies such as vaginal agenesis or an imperforate hymen are exempted and the psychological dysfunction of vaginismus is discounted, it could be said provocatively that there has never been an impotent woman. Woman need only make herself physically available to accomplish coital connection." This admittedly provocative statement was made by *Masters & Johnson* (1970). Yet its provocation exaggerates and misleads. It disregards the many psychological resistances which can prevent a woman from making herself physically available for sexual intercourse. It is true that such psychological resistances are overridden in violent rape situations, when fear of death and injury removes all physical opposition. But in normal circumstances, psychological resistances to sexual activities can be insurmountable. They are, of course, not a prerogative of women, but also occur in men. They are not necessarily neurotic in origin and may owe their power to, for instance, religious vows of chastity. They may prohibit all forms of sexual activities or only those with a particular kind of partner, such as partners of the same or opposite sex.

Other sexual resistances are less sweeping; they are directed against particular individuals only. Among them are resistances which arise unexpectedly and abruptly in the course of a previously satisfying sexual relationship. When this happens to a man, he may fail to achieve or maintain an adequate erection. Fear of further failures can then add to his difficulties and make him impotent. Yet such impotence may be restricted to the habitual sexual partner only and not extend to other women who have the lure of seductive novelty.

When a woman develops a comparable resistance to intercourse with a steady sexual partner, such as her husband, she need not be impotent in the sense that she cannot make herself physically available to him. There need be no fear of failure. There may be no more than an aversion to activities which have lost excitement and satisfaction for her.

There is, however, a particular group of women in whom sexual resistance is based on the unexpected and abrupt emergence of irrational fears of intercourse. In their case, intercourse becomes a phobic situation from which they shrink in dread and panic. Their reactions are in most ways analogous to those experienced by patients whose phobic situations are of a more familiar kind, such as open or closed spaces, crowds, heights, and the like. There is only this difference: the phobic situation in this group of female patients is not intercourse in general, but intercourse with a formerly accepted and sexually satisfying partner. Their phobia is partner-specific and renders them impotent with him alone. Only his advances elicit fear. Other men can still arouse sexual feelings and desires in them. Indeed some patients deliberately seek another sexual partner to prove to themselves that their sex life has not yet come to an end. Others find to their surprise that erotic overtures by another man do not fill them with fear but unaccustomed sexual excitement. The outcome may be a passionate affair which can seriously aggravate an already highly explosive marital situation. It is thus not surprising that divorce and re-marriage is commonplace among many of these patients.

The origin of phobic symptoms which make their first appearance in adult life is usually a mystery. However, in women with partner-specific phobic impotence, clinical observation seems to indicate that the phobias tend to evolve in the course of a depressive episode. Indeed the severity of the phobic reactions can vary with the severity of the depressive disease. Some patients are able to submit to intercourse, when their depressions improve, though the pleasure they derive from such sexual activity remains subdued. In other patients, however, the partner-specific phobic impotence outlasts the depressive episode.

When the phobic reaction is strong, the patient feels forced to avoid almost all physical contact with her partner. When he returns home, she may offer him a cheek to kiss and then anxiously withdraw before his hand can stray to her breasts or buttocks. When the partner makes physical advances in bed, she shrinks from him in rigid, and frigid, fear; she may tearfully beg him to desist; she may develop all kinds of psychosomatic symptoms which make her sexual refusals more plausible. Yet the partners cannot be blamed for often feeling frustrated and resentful. Then there may be occasional scenes of verbal and even physical violence that leave a smouldering residue of ill-feeling and irritability in both partners. On the other hand, if it is possible to reach an agreement with the partner that he will not attempt to have intercourse and if the patient comes to trust him, her fears may melt away to such an extent that she may even engage in close physical cuddling that is mutually enjoyed. It is then quite obvious that it is only direct genital stimulation and intercourse which is the phobic stimulus.

The group of women suffering from phobic partner-specific impotence is by no means small. Moreover, the clinical picture is quite distinctive, once one has learned to recognize it. This leaves one with the puzzling question, why it has found no place of its own in the by now voluminous literature on sexual and marital difficulties. One finds references to the various components of the syndrome, but not to the syndrome as such.

Llewellyn (1974), for instance, mentions that sexual problems and marital conflicts can arise from a phobia of intercourse. He describes a patient who noticed a vaginal discharge some months after marriage, became convinced that she had a venereal disease, and refused to have intercourse with her husband for fear of infecting him. Negative gynaecological findings failed to alleviate her fear. "Before long she elaborated her fear into a dread of intercourse itself." Analysis revealed "that anxiety about her disease and the phobia about infecting her husband in intercourse was a displacement of anxiety about becoming pregnant". In prolonged psychotherapy, the patient gradually accepted this interpretation, and "her concerns about venereal disease and intercourse waned and the relationship improved".

Abse (1974) writes about non-phobic sexual difficulties which are partner-specific. They disappear in forbidden intrigues with a lover. "The commonly reported partial frigidity in marriage often owes something to this paradoxical need for the 'forbiddenness' that promotes maximal sensual pleasure by its correspondence with fantasy." *Abse* describes a woman who "since the birth of her baby two years earlier ... had felt an increasing aversion to sexual intercourse with her husband, leading to total vaginal anaesthesia". But she was capable of clandestine "lovemaking that fell short of actual intercourse" with a young employee of her husband and was both "thrilled with her secret assignations ... and worrying about them". Another of *Abse's* patients complained of depression and "frigidity with her husband, although she occasionally enjoyed sexual satisfaction to orgasm with other men". She "accounted for her depression on the grounds of the loss of sexual pleasure", a loss that eventually spoiled even her extra-marital affairs. Summing up his remarks on partner-specific sexual difficulties, *Abse* said: "We often discover in dealing with severe frigidity within a marriage that we are dealing with a partial regression in the superego ... Basically these patients resist change, even in spite of their protests about having an enlightened attitude towards sex; in such cases nothing but deep-reaching psychoanalysis is likely to effect any considerable psychosexual change."

Sexual and marital difficulties tend to be associated with depressive moods that periodically affect either or both partners. Usually, such depressive moods are reactions to the difficulties experienced. Yet depressive moods and associated anxieties can be the symptoms of an endogenous affective illness as well. In that case, the depressive moods are almost bound to give rise to some sexual or marital difficulties. Moreover, these difficulties and the depressive moods will then mutually aggravate each other. This adds a reactive element even to the clinical manifestations of an endogenous depression.

The distinction between endogenous and reactive depressions is not just an exercise in diagnostic classification. It has important prognostic and therapeutic implications. Many sex therapists have recognized this. *Kaplan* (1974), for instance, emphasizes that endogenous "depression is probably best viewed as a genetically transmitted psychosomatic disorder of brain metabolism ... Treatment is probably best addressed to both the chemical and psychic determinants of the depression" (p. 477). She is aware that, in this context, depressive moods can easily escape detection or proper evaluation. She therefore warns that "the

clinician should be alert for masked depression in either spouse when he evaluates a couple for sex therapy ... It is our practice to treat the depression first and to postpone sexual therapy" (p. 76–77). She also refers to a phobic anxiety syndrome which "probably has a genetic basis which is similar to that of the depressive illnesses. ... [Patients with this syndrome] tend to physically avoid situations which they anticipate may trigger a panic attack. ... Fortunately, this syndrome appears to be highly amenable to simple pharmacological treatment with small doses of tricyclic antidepressants. When one of the partners in a couple seeking sex therapy suffers from phobic anxiety syndrome, it is best to defer sex therapy for a month or so until the anxiety has been brought under control" (p. 479).

There is thus no doubt that the components of phobic partner-specific impotence in women have been noticed. It is only the complete syndrome that has apparently been missed. To find an explanation for this diagnostic scotoma one has to keep in mind that the occurrence of a depressive episode can be obscured by the emotional repercussions it has in a family setting and that the fear of intercourse is so puzzling to the patients themselves that they stress the repugnance and revulsion they feel rather than their dread. Yet when the syndrome is fully developed, it is hard to see why it has been overlooked.

Case report

Miss A.'s father had been suffering from a recurrent depressive illness for which he had received shock treatment on several occasions. She herself had developed a typical endogenous depression some months before coming to see me and she had been troubled by various phobias since then (e.g. crowds, lifts, underground). Her symptoms had started about a year after she had begun to live with Nick, a wealthy bachelor without previous sexual experience. She was strongly aroused by him sexually, though there were initial difficulties in their love-making. The onset of her depression forced her to give up her job and made her housebound for a few months. She became dependent on Nick's care and support. She had no sexual desires and when Nick became amorous, she was overwhelmed by panic and had to free herself from him. In the end, she could not stand being touched by him at all. Nick was hurt and felt rejected. The result were rows and ill-feeling.

She had never had any fear of sexual contact with any of her previous boy friends. She had, however, always had some fear of vaginal penetration. It was not a disabling fear, since it was dispelled by sexual excitement and had never interfered with intercourse before. It had only prevented her from using tampons during menstruation.

When she improved with the help of antidepressant medication, she resumed her occupational career. Her fears of crowds, lifts, etc., receded, but her phobia of physical contact with Nick continued unabated. She could not overcome it, however much she tried. Yet she soon found out that it was only Nick who provoked her phobia. She met a former boy friend one day and noticed with relief that when he held her close, she did not shrink from him in fear, but felt sexually excited. She went to bed with him and found intercourse as satisfying as it had always been. This experience did not, however, affect her phobic impotence with Nick.

She was fond of Nick, had become accustomed to the care, comfort, and luxuries he could provide. They had planned to get married, but realized now that this was out of the question without a proper sex life. In an attempt to alleviate her phobia of sexual contact with Nick, tranylcypromine in the morning was added to the tricyclic antidepressants she was still taking in the evening at that time. This was effective. Love play and intercourse became possible. Unfortunately, this state of comparative bliss lasted only about a fortnight. Then she fell passionately in love with

another man and started a hectic sexual affair which was broken off by him after a few months, when he found her demands on his time and affection too taxing. In the meantime, she had left Nick, but remained on friendly and affectionate terms with him. She has had other lovers since and there have been no sexual difficulties with any of them. There have been recurrences of her depressive illness, but they were mild and could be kept in check with medication.

This patient certainly was strongly motivated to make herself physically available for intercourse with a partner whom she wanted to marry. Unfortunately, her sexual phobia of him did not improve in step with other depressive-phobic symptoms. This is not typical of other patients. When their mood improves, their partner-specific sexual phobia vanishes. However, it usually leaves behind a partner-specific sexual aversion which is not tinged with fear and is no absolute bar to intercourse. The patients can then make themselves available for intercourse, even though half-heartedly and with little enjoyment. Such an aversion can still be a fertile source of ill-feelings between the partners, and the partner-specificity can add its own complications.

Case report

Mrs. B. had been married for 8 years, when she came for treatment. There was no family history of psychiatric illnesses nor any definite evidence of past depressive episodes in her. For some time, she had become critical of her husband with whom she shared few interests. She had begnn to wonder whether she had ever loved him, and had felt she should leave him and lead her own life. Sexual activities had become stale for her, but had not ceased. For several months in the past year, she had been in a hyperthymic state, enjoying the pleasures of life, being full of energy and in need of little sleep. She had started an extramarital affair which came to an end when her depressive symptoms appeared. She was convinced that her marriage was responsible for her miserable mood, listlessness and sense of futility. The cure seemed to lie in separation from her husband. It was at that time that she developed a phobia of physical contact with her husband. They had been in the habit of sleeping naked. Now she had to wear a night dress and keep a safe distance. The marital atmosphere grew cold and disagreeable. The husband became irritable and began to lose his temper. This provided the patient with additional reasons for wishing to leave him.

At that time, the patient was sent to me with the diagnosis of a reactive depression due to marital dysharmony. I came to the conclusion that there was an endogenous element in her depression which seemed to have been the primary cause of the marital dysharmony. I therefore prescribed a monoamine oxidase inhibitor. In a joint session with the husband, the biochemical nature of Mrs. B.'s depression and sexual difficulties was deliberately stressed. Provisional sexual abstinence was advised and the possible need of sex-therapeutic sessions mentioned. A fortnight later, Mrs. B. reported that her depression and sexual fears had vanished and that there had been an enjoyable session of love-making with her husband.

Soon afterwards her depression deepened, but her sexual phobia was now only of intercourse itself, not of its preliminaries as her husband had promised to abstain from it. She now liked snuggling up to him. Only when there were signs that he might want to go beyond snuggling, did she tense up and free herself. Tricyclic antidepressants were now added to her medication in the evening. When her mood improved, she was again able to accept intercourse with her husband occasionally, though she remained averse to it, mainly because of lack of sexual arousal and pleasure, not because she had to overcome irrational fears of it. At the same time, she noticed that other men attracted her sexually. She went to bed with some of them and responded normally. When the question of sex therapy with her husband was raised, she refused to consider it. Eventually, she had an ardent love affair and succeeded in concealing

it from her husband who may, in any case, not have wished to know. There were depressive recurrences which caused guilt feelings about her deceptions, damped her sexual desires for her lover, and made her wish to confess everything to her husband. There were no recurrences of her sexual phobia and early antidepressant medication had its usual beneficial effect. She no longer wished to leave her husband, at least not for the time being. The husband was satisfied with the generally improved atmosphere in the home and the occasional sexual favours he obtained.

There are many variations in the manifestations of the syndrome of phobic partner-specific impotence in women and many are more tempestuous than those in the two cases quoted. When the depression of the patients is mild, it is often obscured by the emotional complications to which it gives rise. Anger and annoyance with the partner loom larger than the dejection of mood. When such dejection is noticed, it is all too readily regarded as purely reactive to an irritating and frustrating situation. The endogenous element in the depression is then missed, unless special efforts are made to uncover feelings of despondency and hopelessness, admissions of self-blame, and evidence of diurnal variations of mood. The phobic nature of the sexual disturbance also tends to escape attention, especially when patients can maintain, and perhaps even convince themselves, that their avoidance of physical contact with their partners is due to the hostilities and animosities that have developed between them. However, when patients are seen on their own and careful enquiries are made, it is generally possible to elicit from them that behind the facade of hostility there lurk fears for which they have no explanation.

When such admissions are obtained, another obstacle is often encountered. The patients do not wish to be regarded as ill. In many arguments with their partners, they had been spitefully accused of being hysterical or mad, of being abnormal and in need of a psychiatrist. Such accusations hurt and have to be proved wrong. Moreover, when a couple first comes for help with marital difficulties, the usual formula is that the blame lies with neither side, that it is the marriage which is in need of treatment and not either partner alone. It is not surprising that many patients are opposed to having this formula revised and to accepting the fact that there had been some truth in the ill-tempered accusations of their partners.

Phobic partner-specific impotence in women can thus be heavily camouflaged. This may partly account for its non-recognition as a clinical syndrome. However, phenomenological considerations and preferences for psychogenic interpretations may also contribute to the non-recognition. Be that as it may, it seems important to become aware of the syndrome behind its camouflage, because it points the way to a therapeutic approach that is often beneficial. The treatment which has proved itself to me consists of a drug-assisted form of psychotherapy. The drugs required are mainly monoamine oxidase inhibitors, though they may have to be combined with tricyclic antidepressants and occasional anxiolytic medication. The psychotherapy takes place mainly in individual sessions, but there are also joint interviews. It consists in straightforward counselling together with a manipulation of emotional and situational factors. The biochemical component of the patient's illness is stressed to lighten the burden of guilt the pa-

tient feels herself and the partner heaps on her. At the same time, it can be pointed out that she is entitled to the same consideration and help as a patient with a predominantly physical illness. Since her illness caused a mood disturbance, it had made her a difficult companion to live with. The partner therefore cannot be blamed for having responded with annoyance and resentment which then rebounded to aggravate the situation cumulatively. It is also emphasized that the patient's avoidance of sex is due to an irrational fear of intercourse which is comparable to other kinds of phobias. If the partner happens to have a phobia of some objectively harmless object or situation himself, he gets at least an inkling of the patient's emotional difficulty. To remove the dread of the phobic situation from the patient, the partner is requested not to attempt intercourse. If he promises to do that and the patient comes to trust him, a good deal of love play can become possible.

When antidepressant medication becomes effective, the patient can be more outgoing and affectionate. This upswing of mood is sometimes consummated in intercourses with the partner. But such successes tend to be short-lived. In some patients, the partner-specific phobia returns in more or less full force; in others, intercourse with the partner loses its dread, but may become uncomfortable or arouse so little pleasure that it is performed as a mere duty or favour. As long as a patient's libido remains dormant and has not been stimulated by another man or other men, sex therapy, modelled on the practices of *Masters & Johnson* (1970), may be initiated at some stage. However, progress is liable to be slow and setbacks common. It is often advisable to facilitate pleasuring sessions by applying anxiolytic measures to the patients which go beyond the usual relaxation practices. They may already have had the experience that convivial evenings with small doses of alcohol can abate their sexual partner-specific phobia or reluctance on a particular occasion. But the use of alcohol for sexual facilitation has its drawbacks, unless the amount taken can be adequately controlled. It is, on the whole, better to resort to occasional doses of benzodiazepine compounds, such as diazepam or nitrazepam. Their proper timing and dosage, however, has to be found by trial and error.

Sex therapy with her customary partner becomes unacceptable to a patient once she has engaged in pleasurable sexual intercourse with other men and especially when she has fallen wildly in love with a particular man. When this happens, the relationship with the customary partner can come to grief. Jealous quarrels and fights can ensue. Separation or divorce is often the ultimate outcome. It is, however, surprising how many marriages can be precariously continued, because the husband has somehow come to terms with the fact that his sexual advances are not welcomed by his wife any more. He may find sexual satisfaction elsewhere or content himself with masturbation. He must then become adept at turning a blind eye on his wife's infidelity or infidelities, when they are not too obviously flaunted. Indeed he often seems to collude with his wife in allowing her sufficient time away from home or him without asking awkward questions or making suspicious enquiries. Yet when a marriage is maintained in this way, one has to be particularly careful to spot depressive relapses in the wife, because there is then the danger that she might attribute

her guilt feelings to the deceptions she practices and attempt to alleviate her remorse by confessing everything to her husband. This can have catastrophic consequences which involve not only the patient's husband and children but perhaps also the family ties of her lover. It is not the task of psychiatrists to pass moral judgements but to forestall unhappiness and suffering, if this can be done. In the interest of everybody concerned, one has to advise the patient against making confessions and one has to subdue her depressive symptoms by appropriate medication so that the uneasy status quo is maintained as long as possible.

REFERENCES

Abse, D. W. (1974): Sexual disorder and marriage. In *Abse, D. W., E. M. Nash & L. M. R. Louden* (eds.): Marital and sexual counseling in medical practice, Ch. 4. Harper & Row, Hagerstown, Maryland, pp. 47, 53.

Kaplan, H. S. (1974): The new sex therapy. Active treatment of sexual dysfunctions. Baillière Tindall, London.

Llewellyn, C. E. (1974): Sexual problems and marital conflict. In *Abse, D. W., E. M. Nash & L. M. R. Louden* (eds.): Marital and sexual counseling in medical practice, Ch. 3. Harper & Row, Hagerstown, Maryland, p. 33.

Masters, W. H., & V. E. Johnson (1970): Human sexual inadequacy. J. & A. Churchill, London, p. 159.

Received December 14, 1977

F. Kräupl Taylor, D.P.M.
The Bethlem Royal and Maudsley Hospitals
22 Redington Road
London NW3 7RG
England